Evidence for change of age shown on FILM NO. G 122 OCT. 19, 1949

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

Bc 08477

CERTIFICATE OF DEATH

Reg. Dist. No. 28

MARGIN RESERVED FOR BINDING — PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH: COUNTY: Anne Arundel; MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Crownsville
LENGTH OF STAY (in this place): 4 mos. 14 days
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Crownsville State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE: Maryland; COUNTY: B. City
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Baltimore
STREET ADDRESS (If rural, give location): 1512 W. Franklin Street

3. NAME OF DECEASED (Type or Print): (First) Mary (Middle) Louise (Last) Barker

4. DATE OF DEATH: (Month) 9/25/49 (Day) (Year) 19

5. SEX: female

6. COLOR OR RACE: colored

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): married

8. DATE OF BIRTH: 7/1/05

9. AGE last birthday: ~~43~~ 44 yrs. If under 1 year: Months ****** Days ****** If under 24 hrs.: Hours ****** Min. ******

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: none

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: not known

14. MOTHER'S MAIDEN NAME: not known

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) ******

16. SOCIAL SECURITY NO. ******

17. INFORMANT: Hospital Records

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		Interval Between Onset and Death
Immediate cause	(a) Pulmonary Edma	known since 9/23/49
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Psychosis with Cardio-Renal Disease	known since ~~5/12/49~~
	(c)	

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION ****** MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) ****** PLACE (Home, farm, factory, street, office bldg., etc.) ****** (CITY OR TOWN) ****** (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) ****** m. INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR? ****

22. I hereby certify that I attended the deceased from 5/12/49, 19....., to 9/25/49, 19....., that I last saw the deceased alive on 9/25/49, 19....., and that death occurred at 5:20A. m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS: Crownsville, Maryland DATE SIGNED: 9/25/49

23. BURIAL, CREMATION, REMOVAL (Specify): Buried | DATE: 9/28/49 | NAME OF CEMETERY OR CREMATORY: Mt. Auburn Cemetery | LOCATION (City, town, or county) (State): Baltimore, Md.

DATE REC'D BY LOCAL REG. 9/28/49 | REGISTRAR'S SIGNATURE: Adw. Hedrick | 24. FUNERAL DIRECTOR: Katie Williams, Baltimore ADDRESS

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

08478

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH: COUNTY Anne Arundel; STATE MARYLAND; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis; LENGTH OF STAY (In this place) 21 days; HOSPITAL OR INSTITUTION OR STREET ADDRESS U.S. Naval Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland; COUNTY Anne Arundel; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Kent Village, Maryland; STREET ADDRESS (If rural give location) 709 Forest Road

3. NAME OF DECEASED (Type or Print): (First) Marjorie (Middle) (none) (Last) BETZER

4. DATE OF DEATH: (Month) September (Day) 13 (Year) 1949

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married

8. DATE OF BIRTH: 9-7-1889

9. AGE last birthday: 60 yrs. If under 1 year: Months; Days. If under 24 hrs.: Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: None

11. BIRTHPLACE (State or foreign country): New York

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Frederick Falls

14. MOTHER'S MAIDEN NAME: Sarah Blakiley

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) - - - - - - (If yes, give war or dates of service) - - - - - -

16. SOCIAL SECURITY NO. - - - - - - - - -

17. INFORMANT: Hospital Records

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

580 **Immediate cause** (a) Atrophy, Liver, Yellow, Acute — Interval Between Onset and Death: 10 weeks

125a **Antecedent cause(s)** Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: September 6, 1949

19b. MAJOR FINDINGS OF OPERATION: Atrophy of Liver

20. AUTOPSY? Yes X No

21. ACCIDENT SUICIDE HOMICIDE (Specify) - - - - - - - PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) - - - - - - - (CITY OR TOWN) (COUNTY) (STATE) -

TIME OF INJURY (Month) (Day) (Year) (Hour) - - - - - - - - - m. INJURY OCCURRED While at Work ☐ Not While At work ☐ HOW DID INJURY OCCUR? - - - - - - - - - - - - - - - - - - -

RECEIVED
SEP 15 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

08479

Reg. Dist. No. 21

1. PLACE OF DEATH: COUNTY Anne Arundel MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS Colonial Gasoline Station Main St. Market Place

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY A. A.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Severnal Park
STREET ADDRESS (If rural, give location) Cypress Creek Rd.

3. NAME OF DECEASED (Type or Print) (First) Walter L. (Middle) Baughan (Last)
4. DATE OF DEATH (Month) Sept. (Day) 17 (Year) 1949
5. SEX M.
6. COLOR OR RACE White
7. ~~SINGLE, MARRIED, WIDOWED~~, DIVORCED, ~~(Specify)~~
8. DATE OF BIRTH 4/16/1883
9. AGE last birthday 66 yrs. If under 1 year Months Days If under 24 hrs. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Gasoline Station Attendant
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Rockford Ill
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Unknown
14. MOTHER'S MAIDEN NAME Unknown
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) yes (If yes, give war or dates of service) 1907-1911
16. SOCIAL SECURITY NO.
17. INFORMANT Edward Baughan Patuxent Naval Base Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Coronary Occlusion — Sudden

420.1

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

94a

(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION None
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☑

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at work ☐ Not while at work ☐
HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☐, Inquiry ☑ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE Gustave H. Faubert M.D. (Degree or title) Lieutenant Deputy M.C. ADDRESS Glen Burnie, Md. DATE SIGNED 9/17/49.

23. BURIAL, ~~CREMATION~~ ~~[illegible]~~ ~~(Specify)~~ DATE THEREOF 9-21-49 NAME OF CEMETERY OR CREMATORY Glen Haven Memorial LOCATION (City, town, or county) Glen Burnie (State) Md

DATE REC'D BY LOCAL REG. Sept. 19, 1949 REGISTRAR'S SIGNATURE [illegible] 24. FUNERAL DIRECTOR John M. Taylor Son ADDRESS Annapolis Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A

RECEIVED
SEP 20 1949
BUREAU V. S.

Briscoe

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

08480

CERTIFICATE OF DEATH

Reg. Dist. No. 26

1. PLACE OF DEATH: COUNTY A. A. MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Shadyside
LENGTH OF STAY (in this place) life
HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md. COUNTY A. A.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Shadyside
STREET ADDRESS (If rural give location)

3. NAME OF DECEASED (Type or Print) (First) Martha (Middle) E. (Last) Briscoe

4. DATE OF DEATH (Month) Sept. (Day) 14 (Year) 1949

5. SEX female
6. COLOR OR RACE colored
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) widow
8. DATE OF BIRTH May 11 1876
9. AGE last birthday 73 yrs. If under 1 year Months 4 Days 3 If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Shadyside
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME Thomas Scott
14. MOTHER'S MAIDEN NAME Grace Scott

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT Mrs. Carrie Nick

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

331 Immediate cause (a) Cerebro vascular accident

Antecedent cause(s)

83a Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 8-22, 1949, to 9-14, 1949, that I last saw the deceased alive on 9-14, 1949, and that death occurred at 1.45 A m., from the causes and on the date stated above.

SIGNATURE P. T. Allen (Degree or title) M D ADDRESS 10 Carroll DATE SIGNED 9-16-49

23. BURIAL, CREMATION REMOVAL (Specify) Burial
DATE Sept. 17 1949
NAME OF CEMETERY OR CREMATORY St Matthews
LOCATION (City, town, or county) Shadyside (State) Md

DATE REC'D BY LOCAL REG. 9/16/49
REGISTRAR'S SIGNATURE J. B. Dent
24. FUNERAL DIRECTOR J. B. Johnson ADDRESS Annapolis

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
SEP 20 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH 08481

CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

Reg. Dist. No. 21

1. PLACE OF DEATH: COUNTY Anne Arundel; CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pasadena; MARYLAND LENGTH OF STAY (In this place) 8 months; HOSPITAL OR INSTITUTION OR STREET ADDRESS Freetown.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland; COUNTY A.A.; CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pasadena; STREET ADDRESS (If rural, give location) Freetown

3. NAME OF DECEASED (Type or Print): (First) Irene (Middle) Sylvester (Last) Carter

4. DATE OF DEATH: (Month) 9 (Day) 13 (Year) 1949

5. SEX: Male

6. COLOR OR RACE: Colored

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Single

8. DATE OF BIRTH: 12/28/48

9. AGE last birthday: yrs. 8; If under 1 year: Months; If under 24 hrs.: Days, Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None

10b. KIND OF BUSINESS OR INDUSTRY: None

11. BIRTHPLACE (State or foreign country): Freetown - Pasadena, Md.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Isaac Carter

14. MOTHER'S MAIDEN NAME: Bertie Coates

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: None

17. INFORMANT: Bertie Carter (mother)

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
571.0 **Immediate cause**	(a) Acute diarrhea	3 days.
119a **Antecedent cause(s)** Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Dehydration	"
	(c)	

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☒

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY

(CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at work ☐ Not while at work ☐

HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☐, Inquiry ☑ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

Everstool V. Parker M.D. coroner & deputy Medical exam. Glen Burnie, Md. 9/13/49

23. BURIAL, CREMATION, REMOVAL (Specify) Burial; DATE THEREOF Sept 15 49; NAME OF CEMETERY OR CREMATORY Marley Neck; LOCATION (City, town, or county) (State) A A Co Md

DATE REC'D BY LOCAL REG. 9-15-49; REGISTRAR'S SIGNATURE K

24. FUNERAL DIRECTOR Isaac L Brownson; ADDRESS 108W Montgomery St

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

08482

CERTIFICATE OF DEATH

Reg. Dist. No. 21

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: COUNTY A A. MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS Ernsted P.O.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md. COUNTY A.A.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Magothy River
STREET ADDRESS (If rural give location)

3. NAME OF DECEASED (Type or Print): (First) James (Middle) Nelson (Last) Cox

4. DATE OF DEATH: (Month) 9 (Day) 13 (Year) 1949

5. SEX Male

6. COLOR OR RACE White

7. ~~SINGLE~~, MARRIED, ~~WIDOWED, DIVORCED~~ (Specify)

8. DATE OF BIRTH 10-12-1867

9. AGE last birthday 81 yrs. If under 1 year: Months Days; If under 24 hrs.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10b. KIND OF BUSINESS OR INDUSTRY Ret.

11. BIRTHPLACE (State or foreign country) A A Co Md

12. CITIZEN OF WHAT COUNTRY U.S.A.

13. FATHER'S NAME Isaac Cox

14. MOTHER'S MAIDEN NAME Elvira Nelson

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. —

17. INFORMANT Dorothy K. Cox - Arnold P.O. Md

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN ONSET AND DEATH

422.1 **Immediate cause** (a) Arteriosclerotic Cardiov. Vascular disease (yrs.)

93d **Antecedent cause(s)** Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Senility.

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 7/1/49, 19....., to 9/13/49, 19....., that I last saw the deceased alive on 9/13/49, 19....., and that death occurred at 2:30 m., from the causes and on the date stated above.

SIGNATURE (Degree or title) Albert H. Leedom - M.D ADDRESS Hartge - Annapolis DATE SIGNED 9/14/49

23. ~~BURIAL~~, CREMATION REMOVAL (Specify) DATE THEREOF 9-16-49 NAME OF CEMETERY OR CREMATORY LOCATION (City, town, or county) (State) Niles Ohio

DATE REC'D BY LOCAL REG. Sept. 14, 1949 REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR John M. Taylor Son ADDRESS Annapolis Md

VS. A15

RECEIVED
SEP 15 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

08483

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 24

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH: COUNTY Anne Arundel MARYLAND; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Edgewater Md.; LENGTH OF STAY (in this place); HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Anne Arundel; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Edgewater Md.; STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print): (First) John (Middle) Henry (Last) Cranford

4. DATE OF DEATH: (Month) Sept. (Day) 3 (Year) 1949

5. SEX: Male

6. COLOR OR RACE: Colored

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married

8. DATE OF BIRTH: April 15 1886

9. AGE last birthday: 63 yrs. If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farming

10b. KIND OF BUSINESS OR INDUSTRY: Farming

11. BIRTHPLACE (State or foreign country): Md

12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: Unknown

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no (If year, give war or dates of service)

16. SOCIAL SECURITY No.: no

17. INFORMANT AND ADDRESS: Wm H. Cranford Woodbine Md

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

334 Immediate cause (a) Hypertension & Encephalopathy — INTERVAL BETWEEN ONSET AND DEATH

Antecedent cause(s)

87 Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY | (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 12-7 1948, to 9-3 1949, that I last saw the deceased alive on 9-1-49, 19..., and that death occurred at 1:15 A m., from the causes and on the date stated above.

SIGNATURE C. J. Cella (Degree or title) MD ADDRESS 10 Carroll DATE SIGNED 9-6-49 Md.

23. BURIAL, CREMATION REMOVAL (Specify) BURIAL | DATE Sept 6. 1949 | NAME OF CEMETERY OR CREMATORY Mount Olivet | LOCATION (City, town, or county) West River (State) Md.

DATE REC'D BY LOCAL REG. Sept 6, 1949 | REGISTRAR'S SIGNATURE Edward Coleman | 24. FUNERAL DIRECTOR W. C. Handley & Son | ADDRESS Galesville Md

X

RECEIVED
SEP 8 1949
BUREAU V. S.

08484

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH · COUNTY: A. A. MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED · STATE: Md. COUNTY: A. A.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Parole — LENGTH OF STAY (in this place): life	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Parole
HOSPITAL OR INSTITUTION OR STREET ADDRESS:	STREET ADDRESS (If rural give location):

3. NAME OF DECEASED (Type or Print) (First) Hattie (Middle) (Last) Diggs			4. DATE OF DEATH (Month) Sept (Day) 4 (Year) 1949		
5. SEX: Female	6. COLOR OR RACE: Colored	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Divorced	8. DATE OF BIRTH: June 6 1900	9. AGE last birthday: 49 yrs.	If under 1 year: Months 2 Days; If under 24 hrs.: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Domestic	10b. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): Annapolis		12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: James Diggs			14. MOTHER'S MAIDEN NAME: Elizabeth Linsay		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT: James Diggs Jr.		

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Carcinoma of the Lungs — May 1949

163

Antecedent cause(s)

47d

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) —

(c) —

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not reinted to the disease or condition causing death. —

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☑
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	(CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from May 1st, 1949, to Sept 4, 1949, that I last saw the deceased alive on Sept 4, 1949, and that death occurred at 11:05 P. m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
R. L. Richardson	M.D.	110 - Clay St. Annapolis, Md.	9/7/49

23. BURIAL, CREMATION REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
Burial	Sept 8, 1949	Brewer Hill	Annapolis	Md.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
Sept. 8, 1949	[illegible]	J. B. Johnson	Annapolis Md

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
SEP 9 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

08485

Reg. Dist. No. 21

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15

1. PLACE OF DEATH · COUNTY: Anne Arundel · STATE: MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Annapolis
LENGTH OF STAY (in this place): one week
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Homewood Convl. Home

2. USUAL RESIDENCE (HOME) OF DECEASED · STATE: Maryland · COUNTY: Anne Arundel
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Annapolis
STREET ADDRESS (If rural give location): 107 ~~Chase Home~~ ~~Md.~~ Ave Monticello Ave.

3. NAME OF DECEASED (Type or Print): (First) Mary (Middle) Willard (Last) Duvall

4. DATE OF DEATH: (Month) September (Day) 15 (Year) 1949

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widowed

8. DATE OF BIRTH: 3-28-1868

9. AGE last birthday: 81 yrs. If under 1 year: Months 5 Days 17 If under 24 hrs.: Hours — Min. —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired - Housewife

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Edward Duvall

14. MOTHER'S MAIDEN NAME: unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Saunders Duvall

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

422.2 **Immediate cause** (a) Congestive Heart Failure — Interval Between Onset and Death: about 2 months

93d **Antecedent cause(s)** Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Cr. Myo-Carditis + Endocardial Changes — Interval: several yrs

(c) Sub Acute Nephritis — Interval: several months

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT ✓ SUICIDE HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan 27, 1949 to Sept 15, 1949, that I last saw the deceased alive on Sept 15, 1949, and that death occurred at 8:30 P m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

Oliver Parvis M.D. Annapolis Md 9/16/49

23. BURIAL, CREMATION REMOVAL (Specify): Burial — DATE THEREOF: Sept 18 1949 — NAME OF CEMETERY OR CREMATORY: Family Cemetery — LOCATION (City, town, or county) (State): Annapolis Neck Rd. Md.

DATE REC'D BY LOCAL REG.: Sept. 17, 1949 — REGISTRAR'S SIGNATURE:

24. FUNERAL DIRECTOR ADDRESS: Ben L. Hopping and Son

RECEIVED
SEP 20 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

08486

CERTIFICATE OF DEATH

Reg. Dist. No. 21

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH
COUNTY: Anne Arundel — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Rural Severn
LENGTH OF STAY (In this place): 26 years
HOSPITAL OR INSTITUTION OR STREET ADDRESS: CRAIN Highway 3½ Mi. So. GLEN BURNIE

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: Maryland — COUNTY: Anne Arundel
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Rural - Severn
STREET ADDRESS (If rural, give location): CRAIN Highway

3. NAME OF DECEASED (Type or Print): (First) Ella (Middle) Leona (Last) Franklin

4. DATE OF DEATH: (Month) Sept (Day) 27 (Year) 1949

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):

8. DATE OF BIRTH: Jan 3 1876

9. AGE Last birthday: 73 yrs. — If under 1 year: Months. Days. If under 24 hrs.: Hours. Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housewife

10b. KIND OF BUSINESS OR INDUSTRY: —

11. BIRTHPLACE (State or foreign country): Anne Arundel Co - Md

12. CITIZEN OF WHAT COUNTRY? U.S

13. FATHER'S NAME: William Upton

14. MOTHER'S MAIDEN NAME: Mary Anne Rogers

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No

16. SOCIAL SECURITY NO.: None

17. INFORMANT: Mrs Mary Thelma Johnson (Daughter)

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

			Interval Between Onset and Death
260	Immediate cause	(a) Uremia	1 week
	Antecedent cause(s)	Chronic Nephritis	unknown
61	Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Hypertensive Cardio-Vascular Disease	3 Years.
		(c) Diabetes Mellitus	10 years

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify):

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY:

(CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from July, 1949, to Sept 27, 1949, that I last saw the deceased alive on Sept 24, 1949, and that death occurred at 6:45 P m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
Edward O Merritt	M.D.	Edgewater Md	9-27-49

23. BURIAL, CREMATION REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	Sept. 30 1949	Cedar Hill	Brooklyn, Md. R.F.D.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
9/29	L. J. DeAlton	Thomas W Singleton	Glen Burnie Md

RECEIVED
OCT 3 1949
BUREAU T. S.

MARYLAND STATE DEPARTMENT OF HEALTH BC

08487

CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

Reg. Dist. No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

M

I

VS. A15A

T

1. PLACE OF DEATH: COUNTY Anne Arundel MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Greenhaven
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS Pasadena P.O.,

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Baltimore
STREET ADDRESS (If rural, give location) 2320 Sydney Ave. ✓

3. NAME OF DECEASED (Type or Print) (First) RUSSELL (Middle) ELY (Last) GRIM
4. DATE OF DEATH (Month) Sept. (Day) 10 (Year) 1949
5. SEX Male
6. COLOR OR RACE White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married
8. DATE OF BIRTH Apr. 8, 1903
9. AGE last birthday 46 yrs. If under 1 year Months Days If under 24 hrs. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Dispatcher
10b. KIND OF BUSINESS OR INDUSTRY TRANFER Co
11. BIRTHPLACE (State or foreign country) Chambersburg. Pa.
12. CITIZEN OF WHAT COUNTRY U.S.A.
13. FATHER'S NAME Harvey Russell Grim
14. MOTHER'S MAIDEN NAME Minnie Bell Ashwood.
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No.
16. SOCIAL SECURITY No. 213-03-4349
17. INFORMANT Anna Grim

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

			INTERVAL BETWEEN ONSET AND DEATH
420.1	Immediate cause	(a) Coronary occlusion	sudden
94a	Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Coronary sclerosis	unknown
		(c)	

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☑

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at work ☐ Not while at work ☐
HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☑, Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE John M. Jaffy M.D. (Degree or title) Deputy Medical Examiner ADDRESS Annapolis Md DATE SIGNED 9-10-49

23. BURIAL, CREMATION, REMOVAL (Specify) Burial
DATE THEREOF Sept 14/49
NAME OF CEMETERY OR CREMATORY Meadowridge
LOCATION (City, town, or county) (State) Washington Blvd.
DATE REC'D BY LOCAL REG. 9/13/49
REGISTRAR'S SIGNATURE Arw. Hedrick
24. FUNERAL DIRECTOR Paul E. Chenaweth Jr. ADDRESS 3615-17 Chestnut Ave.

M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

BC 08488

Reg. Dist. No. 21

1. PLACE OF DEATH: COUNTY Anne Arundel MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Severna Park. LENGTH OF STAY (in this place) 41 days.
HOSPITAL OR INSTITUTION OR STREET ADDRESS Cedar Crest Nursing Home.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY ~~Mitchell~~
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Baltimore
STREET ADDRESS (If rural, give location) 3601 - Rexmere Rd.

3. NAME OF DECEASED (Type or Print) (First) Rosa (Middle) Emma (Last) Haas

4. DATE OF DEATH (Month) Sept. (Day) 21 (Year) 1949

5. SEX F

6. COLOR OR RACE White

7. SINGLE, ~~MARRIED~~, ~~WIDOWED~~, ~~DIVORCED~~, (Specify) single.

8. DATE OF BIRTH 3/21/80

9. AGE last birthday 69 yrs. If under 1 year Months Days If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ?

10b. KIND OF BUSINESS OR INDUSTRY Unknown

11. BIRTHPLACE (State or foreign country) Westminster, Md.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME ?

14. MOTHER'S MAIDEN NAME ?

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No

16. SOCIAL SECURITY NO. ?

17. INFORMANT Cedar Crest N. Home - Records.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
331 Immediate cause	(a) Cerebral Hemorrhage	3 days
83a Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Hypertension	41 days
	(c) General Arterio-sclerosis	41 days

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION —

19b. MAJOR FINDINGS OF OPERATION —

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify) No

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) — m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 8/10, 1949, to 9/20, 1949, that I last saw the deceased alive on 9/20, 1949, and that death occurred at 10 A.m., from the causes and on the date stated above.

SIGNATURE Gustave H. Pauberkus (Degree or title) ADDRESS Glen Burnie, Md. DATE SIGNED 9/21/49.

23. BURIAL, CREMATION REMOVAL (Specify) BURIAL

DATE THEREOF 9-23-49

NAME OF CEMETERY OR CREMATORY WESTERN CEM

LOCATION (City, town, or county) BALTIMORE MD (State)

DATE REC'D BY LOCAL REG. 9-22-49

REGISTRAR'S SIGNATURE L

24. FUNERAL DIRECTOR Mrs Chas A G ROHDE ADDRESS 2327 EDMONDSON AVE

Evidnece for change of age shwon on:

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

08489

FILM No. G 121 SEP 14 1949

CERTIFICATE OF DEATH

Reg. Dist. No. 21

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: COUNTY: Anne Arundel — MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED: STATE: Maryland — COUNTY: A. A. Co.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Annapolis — LENGTH OF STAY (in this place): Life	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Annapolis
HOSPITAL OR INSTITUTION OR STREET ADDRESS: 36 Calvert St.	STREET ADDRESS (If rural give location): 36 Calvert St.

3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last)	4. DATE OF DEATH (Month) (Day) (Year)
Rebecca Ellen Hall	9 — 3 — 1949

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months / Days	If under 24 hrs.: Hours / Min.
Female	Col		4-25-1850	99 yrs.		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife		Annapolis, Md.	

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Joshua Kemaley	Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT
		Bertha Brown

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

334 **Immediate cause** (a) Hypertensive Encephalopathy

87e **Antecedent cause(s)** Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b)

(c)

INTERVAL BETWEEN ONSET AND DEATH

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour)	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?
m.		

22. I hereby certify that I attended the deceased from 8-30, 19 49, to 9-3, 19 49, that I last saw the deceased alive on 9-2-, 19 49 and that death occurred at 4.46 P.M., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
A. T. Allen	M D	10 Carroll	9-6-49

23. BURIAL, CREMATION, REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
	9-7-49	Bruns Hill	Annapolis, Md.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
Sept. 6, 1949	[signature]	Mrs. Charles E. Hicks & Son	

VS. A15

RECEIVED
SEP 7 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

08490

CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

Reg. Dist. No. 78

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A

1. PLACE OF DEATH: COUNTY Anne Arundel — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Randalls | LENGTH OF STAY (in this place) 7 months
HOSPITAL OR INSTITUTION OR STREET ADDRESS Conway Station

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Same — COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN —
STREET ADDRESS — (If rural, give location)

3. NAME OF DECEASED (Type or Print): (First) CAROL (Middle) EUGENE (Last) Harris

4. DATE OF DEATH: (Month) September (Day) 1st (Year) 1949

5. SEX: M.

6. COLOR OR RACE: Colored.

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Single

8. DATE OF BIRTH: 12/4/1948

9. AGE Last birthday: yrs. | If under 1 year: Months 8, Days 26 | If under 24 hrs.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None

10b. KIND OF BUSINESS OR INDUSTRY: None.

11. BIRTHPLACE (State or foreign country): Freeman Hosp. - Washington, D.C.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Unknown

14. MOTHER'S MAIDEN NAME: Catherine Harris

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: Rose Dorsey (Grand Mother)

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Malnutrition. — Sudden.

772.5 158

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) Baby's weight at birth 3 lbs.

(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION — 19b. MAJOR FINDINGS OF OPERATION — 20. AUTOPSY? Yes ☐ No ☒

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH. PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY — (CITY OR TOWN) — (COUNTY) — (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. — INJURY OCCURRED While at work ☐ Not while at work ☐ — HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☐, Inquiry ☒ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE — (Degree or title) acting Assistant Medical Examiner — ADDRESS Glen Burnie, Md. — DATE SIGNED 9/1/49

Gustave A. Rudenstine

23. BURIAL, ~~CREMATION~~ ~~REMOVAL~~ (Specify) — DATE THEREOF 9/2/49 — NAME OF CEMETERY OR CREMATORY Mt. Labor — LOCATION (City, town, or county) Chesterfield — (State) Md.

DATE REC'D BY LOCAL REG. 9/2/49 — REGISTRAR'S SIGNATURE E. F. Joyce Reg — 24. FUNERAL DIRECTOR A. Dorsey — ADDRESS Gambrills Md

RECEIVED
SEP 6 1949
BUREAU V. S.

08491

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Bc

Reg. Dist. No.

1. PLACE OF DEATH · COUNTY: A. A. MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED · STATE: Md. COUNTY:
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Severna Pk. LENGTH OF STAY (in this place):	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Baltimore
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Manhattan Beach	STREET ADDRESS (If rural, give location): 2800 St. Paul St.

3. NAME OF DECEASED (Type or Print)	(First) Dr. JOHN	(Middle) FREDERICK	(Last) HAWKINS, Sr.	4. DATE OF DEATH	(Month) Sept	(Day) 6	(Year) 1949
5. SEX: male	6. COLOR OR RACE: white	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): married	8. DATE OF BIRTH: June 17, 1882	9. AGE last birthday: 67 yrs.	If under 1 year: Months / Days	If under 24 hrs.: Hours / Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Doctor	10b. KIND OF BUSINESS OR INDUSTRY: medical	11. BIRTHPLACE (State or foreign country): Baltimore, Md.	12. CITIZEN OF WHAT COUNTRY?				
13. FATHER'S NAME: John Frederick Hawkins	14. MOTHER'S MAIDEN NAME: Amanda Smith						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) — (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT: Dr. J. Fred Hawkins, Jr. 904 St. Dunstans Rd					

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

331 Immediate cause (a) Coronary Thrombosis

94a Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Cerebral Haemorrhage

(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Hemiplegia R. Side

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from May, 1948 to Sept 6th, 1949, that I last saw the deceased alive on Sept 6th, 1949, and that death occurred at 11:05 P.m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
Denis McGratts	1st	Randall H (30)	9/8/49

23. BURIAL, CREMATION REMOVAL (Specify): Burial	DATE THEREOF: 9/10/49	NAME OF CEMETERY OR CREMATORY: Cedar Hill Cem.	LOCATION (City, town, or county) (State): Balto., Md.
DATE REC'D BY LOCAL REG.: 9/8/49	REGISTRAR'S SIGNATURE: A W Hedrick	24. FUNERAL DIRECTOR: WM. J. TICKNER & SONS	ADDRESS: Balto., Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

08492

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 22

1. PLACE OF DEATH — COUNTY: Anne Arundel — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Dorsey — LENGTH OF STAY (In this place): 71
HOSPITAL OR INSTITUTION OR STREET ADDRESS:

2. USUAL RESIDENCE (HOME) OF DECEASED — STATE: Maryland — COUNTY: A. A.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Dorsey
STREET ADDRESS (If rural, give location): Race Road

3. NAME OF DECEASED (Type or Priot): (First) Alice (Middle) Elizabeth (Last) Hood
4. DATE OF DEATH: (Month) September (Day) 24 (Year) 1949
5. SEX: F
6. COLOR OR RACE: W
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): widowed
8. DATE OF BIRTH: Sept. 4 1878
9. AGE last birthday: 71 yrs. — If under 1 year: Months / Days — If under 24 hrs.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: Home
11. BIRTHPLACE (State or foreign country): Dorsey Maryland
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: Charles A. Giles
14. MOTHER'S MAIDEN NAME: Mary
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkoown): no — (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.:
17. INFORMANT: Louis A. Hood

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Cerebral Haemorrhage — 7 mos.

331 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Arteriosclerosis, generalized — 2 yrs.

186a (c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Traumatic shock from a fall — 24 hrs.

19a. DATE OF OPERATION: ✓
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify): ✓
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) ✓ m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Feb., 1949, to Sept. 24th, 1949, that I last saw the deceased alive on Sept. 24, 1949, and that death occurred at 9.30 P. m., from the causes and on the date stated above.

SIGNATURE: Frank Shipley, M.D. (Degree or title) — ADDRESS: Savage, Md. — DATE SIGNED: 9/25/49

23. BURIAL, CREMATION REMOVAL (Specify): Burial — DATE THEREOF: Sept. 27 1949 — NAME OF CEMETERY OR CREMATORY: Meadowridge Cemetery — LOCATION (City, town, or couoty) (State): Dorsey Maryland
DATE REC'D BY LOCAL REG.: Sept 27-49 — REGISTRAR'S SIGNATURE: Clara Haslup — 24. FUNERAL DIRECTOR: De Witt Donaldson — ADDRESS: Laurel Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
OCT 12 1949
BUREAU V. S.

08493

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 28

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH
COUNTY: Anne Arundel County
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Crownsville, Md.
LENGTH OF STAY (in this place): Since 7/2/49
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Crownsville State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: Maryland
COUNTY: Baltimore City
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Baltimore
STREET ADDRESS (If rural, give location): 1520 Park Avenue ✓

3. NAME OF DECEASED (Type or Print): (First) Georgianna (Middle) (Last) James

4. DATE OF DEATH: (Month) September (Day) 10 (Year) 19 49

5. SEX: Female

6. COLOR OR RACE: Negro

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Single

8. DATE OF BIRTH: about unknown 1869

9. AGE last birthday: 80? yrs. If under 1 year: Months. If under 24 hrs.: Days, Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Cook & Nursemaid

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Virginia

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: George Edward Turner

14. MOTHER'S MAIDEN NAME: Leah Turner

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): (If year, give war or dates of service): No

16. SOCIAL SECURITY NO.:

17. INFORMANT: Hospital Records

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

			Interval Between Onset and Death
334	Immediate cause	(a) Chronic Myocarditis	3 mos.
93d	Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Cerebral Arteriosclerosis	Known since Admission
		(c)	

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: ---

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify): ---

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY: (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour): --- m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from July 2, 19 43, to Sept. 10, 19 49 that I last saw the deceased alive on Sept. 10, 19 49, and that death occurred at 2:30 p.m., from the causes and on the date stated above.

SIGNATURE (Degree or title): Leah Turnerston M.D. ADDRESS: Crownsville, Md. / EASTVILLE, VA. DATE SIGNED: 9/10/49

23. BURIAL, CREMATION, REMOVAL (Specify): Burial DATE: 9-14-1949 NAME OF CEMETERY OR CREMATORY: Family lot LOCATION (City, town, or county) (State): Capsville, Md

DATE REC'D BY LOCAL REG.: 9/12/49 REGISTRAR'S SIGNATURE: A.W. Hedrick

24. FUNERAL DIRECTOR: Holland Funeral Home ADDRESS: 1601 Druid Hill Ave.

ams ✓

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

08494

CERTIFICATE OF DEATH

Reg. Dist. No. 27

1. PLACE OF DEATH: COUNTY Anne Arundel MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Ft. Geo. G. Meade
LENGTH OF STAY (in this place) 3 days
HOSPITAL OR INSTITUTION OR STREET ADDRESS Station Hospital, Ft. Meade.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md. COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Baltimore
STREET ADDRESS (If rural give location) 653 Washington Blvd.

3. NAME OF DECEASED (Type or Print) (First) IRENE (Middle) Gladys (Last) Kelley
4. DATE OF DEATH (Month) Sept. (Day) 6 (Year) 1949
5. SEX F
6. COLOR OR RACE W
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) M
8. DATE OF BIRTH Nov. 30, 1914
9. AGE last birthday 34 yrs. If under 1 year Months Days If under 24 hrs. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE
10b. KIND OF BUSINESS OR INDUSTRY Home
11. BIRTHPLACE (State or foreign country) MARYLAND
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME William Palmer
14. MOTHER'S MAIDEN NAME SARA HAINES
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT Cpl. C. B. Kelley Ft. Meade, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

			INTERVAL BETWEEN ONSET AND DEATH
002	Immediate cause	(a) Pulmonary hemorrhage	10 days
13b	Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Pulmonary tuberculosis	11 mos.
		(c)	

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Sept 5, 1949, to Sept 6, 1949, that I last saw the deceased alive on Sept 6, 1949, and that death occurred at 2:20 A.m., from the causes and on the date stated above.

SIGNATURE Lee M. Howard (Degree or title) M.D. ADDRESS Ft. Geo. G. Meade Sta. Hospital DATE SIGNED 9/6/49

23. BURIAL, CREMATION REMOVAL (Specify) Funeral
DATE THEREOF 9/8/49
NAME OF CEMETERY OR CREMATORY Hampstead
LOCATION (City, town, or county) Hampstead (State) Md

DATE REC'D BY LOCAL REG. 9/7/49
REGISTRAR'S SIGNATURE A. W. Hedrick
24. FUNERAL DIRECTOR William Cook Inc 1217 St Paul St ADDRESS

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

FOR MEDICAL EXAMINERS

08495

Reg. Dist. No. 21

1. PLACE OF DEATH: COUNTY Anne Arundel MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Glen Burnie
LENGTH OF STAY (In this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS in Albrecht's Pharmacy

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Baltimore - 16
STREET ADDRESS (If rural, give location) 2203 Monticello ~~Ave~~ Road

3. NAME OF DECEASED (Type or Print) (First) DAVID (Middle) MEYER (Last) KIRSHNER
4. DATE OF DEATH (Month) Sept (Day) 2 (Year) 1949
5. SEX male
6. COLOR OR RACE white
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Divorced
8. DATE OF BIRTH Apr. 14 1891
9. AGE last birthday 58 yrs. If under 1 year Months Days If under 24 hrs. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Pharmacist
10b. KIND OF BUSINESS OR INDUSTRY Pharmacy
11. BIRTHPLACE (State or foreign country) Baltimore
12. CITIZEN OF WHAT COUNTRY U.S.A.
13. FATHER'S NAME Philip Kirshner
14. MOTHER'S MAIDEN NAME unknown
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO.
16. SOCIAL SECURITY NO. 219-12-7569
17. INFORMANT Mrs. Ruth Brown

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

			INTERVAL BETWEEN ONSET AND DEATH
260	Immediate cause	(a) Coronary occlusion	sudden
61	Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Coronary sclerosis	"
		(c) Diabetes Mellitus	unknown

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☑

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at work ☐ Not while at work ☐
HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☑, Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE John M. Caffy M.D. (Degree or title) Deputy Medical Examiner ADDRESS Annapolis Md DATE SIGNED 9-2-49

23. BURIAL, CREMATION, REMOVAL (Specify) Burial
DATE THEREOF Sept 4/49
NAME OF CEMETERY OR CREMATORY Windsor Mill Rd Cemetery
LOCATION (City, town, or county) Balto Md. (State)

DATE REC'D BY LOCAL REG. Sept 3-1949
REGISTRAR'S SIGNATURE R.W.
24. FUNERAL DIRECTOR Sol Levenson & Bros W Northave ADDRESS 1126

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A

2 PM

08496

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH: COUNTY Ann Arundel MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis
LENGTH OF STAY (in this place) 5 yrs
HOSPITAL OR INSTITUTION OR STREET ADDRESS 21 East St

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis
STREET ADDRESS (If rural, give location) 21 East St

3. NAME OF DECEASED (Type or Print) (First) Lena (Middle) (Last) Kotzin
4. DATE OF DEATH (Month) 9 (Day) 25 (Year) 1949
5. SEX Female
6. COLOR OR RACE White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Widow
8. DATE OF BIRTH About 1874
9. AGE last birthday 75 yrs. If under 1 year Months Days If under 24 hrs. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Lith
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME Julman
14. MOTHER'S MAIDEN NAME Not Known
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT Hesse Kotzin

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Cerebral Hemorrhage left hemiplegia	1 week
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b)	
	(c) Arteriosclerosis Generalized	Several years

331
83a

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION None
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Sept 18, 1949, to Sept 25, 1949, that I last saw the deceased alive on Sept 25, 1949, and that death occurred at 7 A m., from the causes and on the date stated above.

SIGNATURE George C Basil (Degree or title) M.D ADDRESS Annapolis Md DATE SIGNED 9.25.49

23. BURIAL, CREMATION REMOVAL (Specify) Burial
DATE THEREOF 9-26-49
NAME OF CEMETERY OR CREMATORY Hebrew Herbing Kern
LOCATION (City, town, or county) Balto (State) Md

DATE REC'D BY LOCAL REG. 9/26/49
REGISTRAR'S SIGNATURE A. W. Hedrick
24. FUNERAL DIRECTOR Jack Lewis Inc ADDRESS 2100 Eutaw Pl

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

08497

CERTIFICATE OF DEATH

Reg. Dist. No. 25

1. PLACE OF DEATH:
County: A. A Co.
City or town: Brooklyn
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred: 1901 Moore St.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: A. A.
City or town: Brooklyn
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 1901 Moore St.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Jacob Krasny

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M Male	White	Married

6.(b) Name of ~~husband or~~ wife: Amelia Krulemick
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Jan. 14th 1879

8. AGE:	Years	Months	Days	If less than one day
	70			hrs. min.

9. Birthplace: Austria (Town, county, and state)
10. Usual occupation: Painter (Retired Wkr)
11. Industry or business

FATHER 12. Name	Pete Krasny
FATHER 13. Birthplace	Austria
MOTHER 14. Maiden name	Not Known
MOTHER 15. Birthplace	

16. Informant: Mrs Amelia Krasny
Address: 1901 Moore St.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 9/20/49 (month) (day) (year)
Cemetery or crematory: Holy Cross
Location: A. A. Co.

18. Funeral director: D. J. Fanning & Son
Address: 1938 E. Lafayette ave.

19. Sept 20 1949 (Date rec'd by registrar) C. W. Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 9/17 1949 at 3A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 17 1949 to Sept 17 1949
and that I last saw h[illegible] alive on Sept. 16 1949

	DURATION
Immediate cause of death: Intestinal Obstruction	4 days
Due to: Metastatic Carcinoma to liver and peritonitis	?
Due to: Primary Malignancy of descending colon	?
Other conditions: 153 462	

(Include pregnancy within 3 months of death)

Major findings of operations: none Date of op.
Autopsy results: none
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Paul Lubin M.D.
M. D. or other
Address: 320 Patapsco Ave. Date signed: 9/19/49

VS A15 9-45-15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

08498

Reg. Dist. No. 22

1. PLACE OF DEATH
COUNTY: A.A. — STATE: MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Jessups
LENGTH OF STAY (in this place): 17 days
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Md. House of Correction

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: Maryland — COUNTY: ------
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Baltimore
STREET ADDRESS (If rural give location): 646 W. Fayette St.

3. NAME OF DECEASED (Type or Print): (First) Len (Middle) (Last) Love

4. DATE OF DEATH: (Month) 9 (Day) 14 (Year) 1949

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widowed

8. DATE OF BIRTH: Dec. 8, 1892

9. AGE last birthday: 56 yrs. If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Labor

10b. KIND OF BUSINESS OR INDUSTRY: Laborer

11. BIRTHPLACE (State or foreign country): Norfolk, Virginia

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: ----------

14. MOTHER'S MAIDEN NAME: ----------

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: Patient

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Edema of lungs.

141 Antecedent cause(s)

45b Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Cancer of lung, metastasis from cancer of tongue.

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: April 9, 1947

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY

(CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Aug. 29, 1949, to Sept. 14 1949, that I last saw the deceased alive on Sept. 14, 1949, and that death occurred at 5:45 p.m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

John A Clark

John A. Clark M.D., Physician in Charge, - M.H.C., Jessups, Md. Sept. 15, 1949

23. BURIAL, CREMATION REMOVAL (Specify): Removal — DATE: 2 — NAME OF CEMETERY OR CREMATORY: Humphries Va — LOCATION (City, town, or county) (State): Humphries Va

DATE REC'D BY LOCAL REG.: Sept 17 49 — REGISTRAR'S SIGNATURE: Clara Kaslich

24. FUNERAL DIRECTOR — ADDRESS: Cunningham Funeral Home Inc. Alexandria Va

VS-A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

RECEIVED
OCT 12 1949
BUREAU U. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

08499

CERTIFICATE OF DEATH

Reg. Dist. No. 21

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: COUNTY Anne Arundel — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis — LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS U.S. Naval Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland — COUNTY Anne Arundel
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Eastport RFD#3
STREET ADDRESS (If rural give location) Barbud Lane

3. NAME OF DECEASED (Type or Print): (First) Priscilla (Middle) (none) (Last) LUTTRELL

4. DATE OF DEATH: (Month) 9 (Day) 18 (Year) 1949

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widowed

8. DATE OF BIRTH: 1-24-1884

9. AGE last birthday: 65 yrs. — If under 1 year: Months / Days — If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: - - - -

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Miles Shorey

14. MOTHER'S MAIDEN NAME: Mary Edmonds

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: Hospital Records

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

420.0
93d

Immediate cause (a) CEREBRAL ANOXIA — 12 hours

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last
(b) CEREBRAL EMBOLISM — 4 days
ARTERIOSCLEROTIC HEART DISEASE
(c) HYPERTENSIVE CARDIOVASCULAR DISEASE — 3 years

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. AURICULAR FIBRILLATION

19a. DATE OF OPERATION - - - - - - - - — 19b. MAJOR FINDINGS OF OPERATION - - - - - - - - — 20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) - - - - - - — PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY - - - - - - — (CITY OR TOWN) - - - - — (COUNTY) - - - - — (STATE) - - - -

TIME OF INJURY (Month) (Day) (Year) (Hour) - - - - - - m. — INJURY OCCURRED While at Work ☐ Not While At work ☐ — HOW DID INJURY OCCUR? - - - - - - - - - - - - - - - - - -

22. I hereby certify that I attended the deceased from 9-14-, 1949, to 9-18-, 1949, that I last saw the deceased alive on 9-18-, 1949, and that death occurred at 11:20 P.m., from the causes and on the date stated above.

SIGNATURE G.M. DAVIS (Degree or title) — ADDRESS CDR., MC, USN U.S. Naval Hospital, Annapolis, Md. — DATE SIGNED 9-19-49

23. BURIAL, ~~CREMATION~~ REMOVAL (Specify) — DATE THEREOF 9-22-49 — NAME OF CEMETERY OR CREMATORY Maryland Memorial — LOCATION (City or County) Baltimore — (State) Md.

DATE REC'D BY LOCAL REG. Sept. 21, 1949 — REGISTRAR'S SIGNATURE — 24. FUNERAL DIRECTOR John M. Taylor Son — ADDRESS Annapolis Md

VS. A15

RECEIVED
SEP 23 1949
BUREAU U. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

08500

CERTIFICATE OF DEATH

Reg. Dist. No. 2.6

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Deale

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 80 yrs.

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Anne Arundel

City or town: Deale

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

James Morris Marshall

3. (b) Social Security Number

none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife: Violetta Rogers

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): ?

8. AGE: Years: 80 | Months: | Days: | If less than one day ..... hrs. ..... min.

9. Birthplace: Parkers Island, A.A.Co.Md.

(Town, county, and state)

10. Usual occupation: Waterman

11. Industry or business

FATHER

12. Name: William S. Marshall

13. Birthplace: Parkers Island

MOTHER

14. Maiden name: Rouches

15. Birthplace: Kent Island Md

16. Informant: Percy Marshall

Address: Deale

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Sept.11/49 (month) (day) (year)

Cemetery or crematory: Deale

Location: Deale, MD.

16. Funeral director: T.A.Hardesty & Son

Address: Galesville, Md.

19. Sept 10 1949 J. B. Dent

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 9 Sept 1949, at 5 00 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 1949, to Sept 1949 and that I last saw him alive on 2 Sept 49 19

Immediate cause of death	DURATION
Cachexia	1 mos
Due to Generalized arteriosclerosis	2 wk.
Due to	
Other conditions	

450.0

97

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: R B Farmer M.D. ~~M. D. or other~~

Address: Upper Marlboro Md Date signed: 9 Sept 49

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
SEP 13 1949
BUREAU V. S.

08501

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:

County A.A.Co., Md

City or town Pasdanea Md
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Md County

City or town Pasdena
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME John H. Matthews

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	C	M

6.(b) Name of husband or wife Lucretia

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) August 6, 1892

8. AGE:

Years	Months	Days	If less than one day
57			..... hrs. ..... min.

9. Birthplace A.A.Co., Md
(Town, county, and state)

10. Usual occupation Labore

11. Industry or business Galvanizing Co

FATHER
12. Name John H. Matthews
13. Birthplace Md

MOTHER
14. Maiden name Jane Dorsey
15. Birthplace Md

16. Informant Lucretia Matthews

Address Pasadena Md

Burial
(Burial, cremation, or removal. Which?)

Date thereof 9/25/49
(month) (day) (year)

Cemetery or crematory Marley St

Location Marley Road

18. Funeral director Isaiah L. Brown & Son

Address 108 W Montgomery St

19. 9/25 19 49
(Date rec'd by registrar)

L. J. DeAlba
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH September 22 19 49 at 11- 5 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 9-13-49 19 to 9-22 19 49 and that I last saw him alive on 9-21-49 19

Immediate cause of death Intracranial Hypertension

Due to

Due to

Other conditions 444 102
(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE G. T. Allen
M. D. or other

Address 10 Carroll Date signed 9-23-49

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

RECEIVED
SEP 30 1949
BUREAU V. S.

08502

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 28

1. PLACE OF DEATH · COUNTY: Anne Arundel County MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED · STATE: Maryland COUNTY: Balto. City
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Crownsville, Md. LENGTH OF STAY (in this place): 9 mos.	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Baltimore
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Crownsville State Hospital	STREET ADDRESS (If rural, give location): 1610 McCulloh Street ✓

3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last): Harry McPherson			4. DATE OF DEATH (Month) (Day) (Year): September 10 1949		
5. SEX: Male	6. COLOR OR RACE: Negro	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married	8. DATE OF BIRTH: 1/16/89	9. AGE last birthday: 60 yrs.	If under 1 year: Months. Days; If under 24 hrs.: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer	10b. KIND OF BUSINESS OR INDUSTRY: Chicken farm		11. BIRTHPLACE (State or foreign country): Washington, D. C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Robert McPherson			14. MOTHER'S MAIDEN NAME: Lydia Johnson		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service): Unknown		16. SOCIAL SECURITY NO.	17. INFORMANT: Hospital Records		

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

			INTERVAL BETWEEN ONSET AND DEATH
331	Immediate cause	(a) Cerebral Hemmorhage	3 days
83a	Antecedent cause(s)		Known since
	Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Cerebral Arteriosclerosis	12/7/48
		(c)	

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: ----	19b. MAJOR FINDINGS OF OPERATION: ----	20. AUTOPSY? Yes ☐ No ☒
21. ACCIDENT SUICIDE HOMICIDE (Specify): ----	PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): ----	(CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour): ---- m.	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR? ----

22. I hereby certify that I attended the deceased from 12/7, 1948, to 9/10, 1949, that I last saw the deceased alive on 9/10, 1949, and that death occurred at 8:15 p. m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
Jacob Marcuston	M.D.	Crownsville, Maryland	9/12/49

23. BURIAL, CREMATION ~~REMOVAL~~ (Specify)	DATE: 9/23/49	NAME OF CEMETERY ~~OR CREMATORY~~: Hospital	LOCATION (City, town, or county) (State): Crownsville Md
DATE REC'D BY LOCAL REG.: 9/23/49	REGISTRAR'S SIGNATURE: E F Joya Local Reg.	24. FUNERAL DIRECTOR: Supt Hospital Crownsville Md	ADDRESS

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
SEP 26 1949
BUREAU V. S.

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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH: COUNTY A. A. MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS Emergency Hospt.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md COUNTY A. A.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Eastport
STREET ADDRESS (If rural give location) 1103 Van Buren Ave

3. NAME OF DECEASED (Type or Print) (First) Grace (Middle) Elinor (Last) Melville
4. DATE OF DEATH (Month) Sept (Day) 8th (Year) 1949
5. SEX F
6. COLOR OR RACE W.
7. ~~SINGLE~~, ~~MARRIED~~, WIDOWED, ~~DIVORCED~~, (Specify)
8. DATE OF BIRTH 11-13-1883
9. AGE last birthday 65 yrs. If under 1 year Months Days If under 24 hrs. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
10b. KIND OF BUSINESS OR INDUSTRY —
11. BIRTHPLACE (State or foreign country) Nova Scotia
12. CITIZEN OF WHAT COUNTRY U.S.A.
13. FATHER'S NAME Samuel Groves
14. MOTHER'S MAIDEN NAME Gracina F. Slocomb
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. —
17. INFORMANT Mrs J. F. Blose Eastport Md

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

			INTERVAL BETWEEN ONSET AND DEATH
153	Immediate cause	(a) Generalized carcinomatosis	8 mos.
46e	Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Carcinoma of transverse colon	4 yrs.
		(c)	

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 1947
19b. MAJOR FINDINGS OF OPERATION Carcinoma of transverse colon, liver metastases
20. AUTOPSY? Yes ☐ No ☑

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from June, 1947, to Sept 8, 1949, that I last saw the deceased alive on Sept 8, 1949, and that death occurred at 6.40 P m., from the causes and on the date stated above.

SIGNATURE (Degree or title) S. Borssuch - M.D. ADDRESS Annapolis Md DATE SIGNED 9/8/49

23. ~~BURIAL~~, ~~CREMATION~~ REMOVAL (Specify) DATE THEREOF 9-9-49 NAME OF CEMETERY OR CREMATORY LOCATION (City, town, or county) (State) Lynn Mass.

DATE REC'D BY LOCAL REG. Sept. 9, 1949 REGISTRAR'S SIGNATURE [signature]
24. FUNERAL DIRECTOR John M. Taylor Son ADDRESS Annapolis Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

EIVED
12 1949
RUREAU V. S.

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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 28

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MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: COUNTY Anne Arundel County MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Crownsville
LENGTH OF STAY (In this place) 32 years
HOSPITAL OR INSTITUTION OR STREET ADDRESS Crownsville State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Charles
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Bryantown
STREET ADDRESS (If rural, give location) ✓

3. NAME OF DECEASED (Type or Print) (First) Jane (Middle) (Last) Middleton
4. DATE OF DEATH (Month) 9 (Day) 22 (Year) 49
5. SEX Female
6. COLOR OR RACE Negro
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Single
8. DATE OF BIRTH About 1901
9. AGE last birthday 48 yrs. If under 1 year: Months. Days. If under 24 hrs.: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
10b. KIND OF BUSINESS OR INDUSTRY None
11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.
13. FATHER'S NAME Richard Butler
14. MOTHER'S MAIDEN NAME Kate Middleton
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)
16. SOCIAL SECURITY No. - - - - -
17. INFORMANT Hospital Records

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Cerebral Hemmorhage	2 days
331 Antecedent cause(s)		
83a Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Cerebral arteriosclerosis	
	(c) Hypertension	

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Feeblemindness without psychosis — Known to us since adm. 11/10/16

19a. DATE OF OPERATION - - -
19b. MAJOR FINDINGS OF OPERATION - - - - - -
20. AUTOPSY? Yes ☐ No ☐

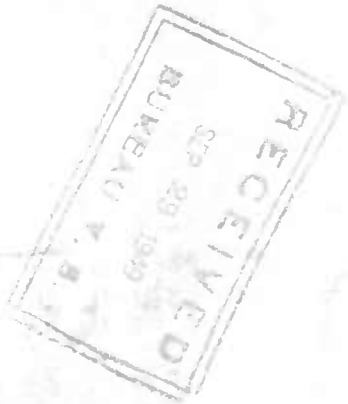
21. ACCIDENT SUICIDE HOMICIDE (Specify) - - - -
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) - - - - - (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) - - - - - m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR? - - - - - - - - - - - - -

22. I hereby certify that I attended the deceased from 10/13, 1941, to 9/21, 1949, that I last saw the deceased alive on 9/21, 1949, and that death occurred at 1:20 A. m., from the causes and on the date stated above.

SIGNATURE Jacob Morrectstein (Degree or title) M.D. ADDRESS Crownsville, Maryland DATE SIGNED 9/22/49

23. BURIAL, ~~CREMATION~~ ~~REMOVAL~~ (Specify) DATE 9/27/49 NAME OF CEMETERY ~~OR CREMATORY~~ Hospital LOCATION (City, town, or county) Crownsville (State) Md

DATE REC'D BY LOCAL REG. 9-27-49 REGISTRAR'S SIGNATURE E. F. Joyce Local Reg
24. FUNERAL DIRECTOR Supt Hospital ADDRESS Crownsville Md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VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH: COUNTY Anne Arundel MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Elvaton Hghts; Millersville, Md. LENGTH OF STAY (in this place) None
HOSPITAL OR INSTITUTION OR STREET ADDRESS Ritchie Highway Route 2 1/2mile south of Elvaton Rd.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Anne Arundel
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Elvaton Heights, Millersville Md
STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print) (First) Willei (Middle) Thomas (Last) Morris

4. DATE OF DEATH (Month) Sept. (Day) 25, (Year) 1949

5. SEX Male | 6. COLOR OR RACE White | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Single | 8. DATE OF BIRTH Oct. 10, 1927 | 9. AGE last birthday 21 yrs. | If under 1 year Months Days | If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer, Pipe fitting | 10b. KIND OF BUSINESS OR INDUSTRY Well digging | 11. BIRTHPLACE (State or foreign country) McGaheysville Virginia | 12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME George Thomas Morris | 14. MOTHER'S MAIDEN NAME Alice Virginia Freeze

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. 215-22-3481 | 17. INFORMANT Mrs. Alice V. Morris Schalizki

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Internal Hemorrhage.	sudden.
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Hemorrhage - due to com -	sudden.
	(c) Pound fractures of both legs.	

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170C

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT ~~SUICIDE~~ ~~HOMICIDE~~ (Specify) Accident | PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Highway no 2 | (CITY OR TOWN) Elvaton, (COUNTY) A.A. (STATE) Md.

TIME OF INJURY (Month) (Day) (Year) (Hour) 9-26-1949 P.M. | INJURY OCCURRED While at Work ☐ Not While At work ☑ | HOW DID INJURY OCCUR? Passenger in automobile on Ritchie Highway Route no 2

22. I hereby certify that I attended the deceased from ——, 19....., to ——, 19....., that I last saw the deceased alive on ——, 19....., and that death occurred at 8.50 P.m., from the causes and on the date stated above.

SIGNATURE Gustave H. Faubert M.D. (Degree or title) assistant deputy medical examiner. ADDRESS Glen Burnie, Md. DATE SIGNED 9/26/49

23. BURIAL, CREMATION REMOVAL (Specify) Burial | DATE THEREOF Sept. 28, 49 | NAME OF CEMETERY OR CREMATORY Western | LOCATION (City, town, or county) Baltimore, Md. (State)

DATE REC'D BY LOCAL REG. 9-28-49 | REGISTRAR'S SIGNATURE L. J. De Alba | 24. FUNERAL DIRECTOR Thomas W. Singleton | ADDRESS Glen Burnie, Md

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RECEIVED
SEP 30 1949
BUREAU OF S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

08506

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH· COUNTY: Anne Arundel MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED· STATE: Md. COUNTY: A.A.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Annapolis — LENGTH OF STAY (in this place):	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Harwood
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Emergency Hospital	STREET ADDRESS (If rural give location):

3. NAME OF DECEASED (Type or Print) (First) Clarence (Middle) M (Last) Paddy			4. DATE OF DEATH (Month) Sept. (Day) 9 (Year) 1949			
5. SEX: Male	6. COLOR OR RACE: White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH: Nov 7, 1947	9. AGE last birthday: 1 yrs.	If under 1 year: Months 10, Days 2	If under 24 hrs.: Hours —, Min. —
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country): Annapolis Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME: Clarence C. Paddy			14. MOTHER'S MAIDEN NAME: Elizabeth A. Rameter			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) — (If yes, give war or dates of service) —	16. SOCIAL SECURITY NO.		17. INFORMANT			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

571.0 Immediate cause (a) Cerebral hemorrhage

119a Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) acute colitis

(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. dehydration and acidosis

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☑ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify) no	PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) —	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from Sept 2nd, 1949, to Sept 9, 1949, that I last saw the deceased alive on Sept 9, 1949, and that death occurred at 8:55 p.m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
Emily H. Wilson, M.D.		Lothian, Md.	9/10/49

23. BURIAL, CREMATION REMOVAL (Specify): Burial	DATE THEREOF: Sept 11, 49	NAME OF CEMETERY OR CREMATORY: Mt Zion Cemetery	LOCATION (City, town, or county) (State): Mt Zion, Md.
DATE REC'D BY LOCAL REG.: Sept. 11, 1949	REGISTRAR'S SIGNATURE: [signature]	24. FUNERAL DIRECTOR: R. S. Hopping & Son	ADDRESS: Annapolis

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
SEP 14 1949
BUREAU T. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

08507

Reg. Dist. No. 7-1

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15

1. PLACE OF DEATH: COUNTY Anne Arundel — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Linthicum Heights | LENGTH OF STAY (In this place) 32 years
HOSPITAL OR INSTITUTION OR STREET ADDRESS 410 Hawthorne Road

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland — COUNTY Anne Arundel
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Linthicum Heights
STREET ADDRESS (If rural, give location) 410 Hawthorne Road

3. NAME OF DECEASED (Type or Print): (First) SAMUEL (Middle) EUCLID (Last) PAUL

4. DATE OF DEATH: (Month) (Day) (Year) September 19, 1949

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widowed

8. DATE OF BIRTH: Oct. 8, 1883

9. AGE last birthday: 65 yrs. | If under 1 year: Months | Days | If under 24 hrs.: Hours | Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Railroad coach Builder

10b. KIND OF BUSINESS OR INDUSTRY: Southern R R

11. BIRTHPLACE (State or foreign country): Benton, Tennesse

12. CITIZEN OF WHAT COUNTRY? U S

13. FATHER'S NAME: James Temple Paul

14. MOTHER'S MAIDEN NAME: Newell Darr

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 381-09-5702

17. INFORMANT: Henry T. Paul

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		Interval Between Onset and Death
Immediate cause	(a) Congestive Heart Failure	Aug. 23, 1949
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Chronic Myocarditis	Unknown
422.2 93d	(c) Acute Nephritis	Sept. 10 1949

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. None

19a. DATE OF OPERATION: None

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify): None

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY | (CITY OR TOWN) | (COUNTY) | (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jun. 22., 1949, to Sept. 18., 1949, that I last saw the deceased alive on Sept. 18, 1949, and that death occurred at 7.15 A.m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

V. E. Spitznagle, M.D. 415 Camp Meade Road, Linthicum Heights, Md. Sept. 20, 1949

23. BURIAL, CREMATION, REMOVAL (Specify): Burial | DATE THEREOF: Sept. 21, 49 | NAME OF CEMETERY OR CREMATORY: Holy Cross | LOCATION (City, town, or county) (State): Brooklyn, R.F.D. Maryland

DATE REC'D BY LOCAL REG. 9/21/49 | REGISTRAR'S SIGNATURE | 24. FUNERAL DIRECTOR ADDRESS: Thomas W. Singleton, Glen Burnie, Md.

RECEIVED
SEP 28 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

08508

Reg. Dist. No. 21

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH
COUNTY Anne Arundel MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Riviera Beach
LENGTH OF STAY (in this place) 9 yrs
HOSPITAL OR INSTITUTION OR STREET ADDRESS 3 Wanda Road

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE Md. COUNTY a.a
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Riviera Beach
STREET ADDRESS (If rural, give location) 3 Wanda Road

3. NAME OF DECEASED (Type or Print) (First) EUNICE (Middle) N. (Last) PHILLIPS

4. DATE OF DEATH (Month) Sept (Day) 26 (Year) 1949

5. SEX Female

6. COLOR OR RACE White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married

8. DATE OF BIRTH Nov 7. 1882

9. AGE last birthday 66 yrs. If under 1 year: Months. Days. If under 24 hrs.: Hours. Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife

10b. KIND OF BUSINESS OR INDUSTRY at Home

11. BIRTHPLACE (State or foreign country) Bethel Del.

12. CITIZEN OF WHAT COUNTRY? U.S

13. FATHER'S NAME Jacob Colbourn

14. MOTHER'S MAIDEN NAME Lucetta Williams

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) —
(If year, give war or dates of service) —

16. SOCIAL SECURITY NO. —

17. INFORMANT Dr. Thomas H. Phillips

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Myocardial failure

200.1

Antecedent cause(s)

55e

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Lympho-sarcomatis

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION No

19b. MAJOR FINDINGS OF OPERATION No

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) No

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY Home (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) 9 - 26 - 49 10 a.m.

INJURY OCCURRED While at Work ☐ Not While At work ☒

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Aug 1, 1949, to 9-26-49, 1949, that I last saw the deceased alive on Sept 20, 1949, and that death occurred at 10 20 a.m., from the causes and on the date stated above.

SIGNATURE John E. Legge (Degree or title) ADDRESS 700 Cathedral St-Balto DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify) Burial

DATE Sept 29/49

NAME OF CEMETERY OR CREMATORY Bethel

LOCATION (City, town, or county) Bethel (State) Delaware

DATE REC'D BY LOCAL REG. 9/27/49

REGISTRAR'S SIGNATURE Ada Hedrick

24. FUNERAL DIRECTOR Mr. & Mrs. John W. Teufel & Son ADDRESS 5311 Edmondson Ave

M

I

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

08509

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH: COUNTY Anne Arundel MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis
LENGTH OF STAY (in this place) 8 days
HOSPITAL OR INSTITUTION OR STREET ADDRESS Emergency Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Sbodyside COUNTY A.A.Co.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Sbodyside - A.A.Co.
STREET ADDRESS (If rural give location) R.F.D. No. 111

3. NAME OF DECEASED (Type or Print) (First) William (Middle) Thomas (Last) Rogers

4. DATE OF DEATH (Month) Sept. (Day) 9 (Year) 1949

5. SEX Male
6. COLOR OR RACE White
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) married
8. DATE OF BIRTH Nov. 14, 1864
9. AGE last birthday 85 yrs. If under 1 year Months 9 Days 27 If under 24 hrs. Hours — Min. —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter
10b. KIND OF BUSINESS OR INDUSTRY Word
11. BIRTHPLACE (State or foreign country) Sbodyside - A.A.Co. Md
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME William Rogers
14. MOTHER'S MAIDEN NAME 0

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No
16. SOCIAL SECURITY NO. None
17. INFORMANT Minnie Rogers

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

422.1 Immediate cause (a) Bronchi-pneumonia (Terminal.)

93d Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) arteriosclerotic cardio-vascular disease

(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION None
19b. MAJOR FINDINGS OF OPERATION —
20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Sept 2, 1949, to Sept 9, 1949, that I last saw the deceased alive on Sept 9, 1949, and that death occurred at 4 A.M. m., from the causes and on the date stated above.

SIGNATURE Albert L. Anderson MD (Degree or title) ADDRESS Annapolis, Md. DATE SIGNED 9/9/49

23. BURIAL, CREMATION REMOVAL (Specify) Burial
DATE THEREOF Sept 12 1949
NAME OF CEMETERY OR CREMATORY Quaker
LOCATION (City, town, or county) Galesville Md (State)

DATE REC'D BY LOCAL REG. Sept. 11, 1949
REGISTRAR'S SIGNATURE [signature]
24. FUNERAL DIRECTOR T A Hardesty & Son ADDRESS

RECEIVED
SEP 14 1949
BUREAU T. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

08510

CERTIFICATE OF DEATH

Reg. Dist. No. 2

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH: COUNTY: Anne Arundel; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Herald Harbor; HOSPITAL OR INSTITUTION OR STREET ADDRESS: Herald Harbor Beach; MARYLAND LENGTH OF STAY (in this place)

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE: Maryland; COUNTY: Anne Arundel; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Herald Harbor; STREET ADDRESS (If rural, give location): Herald Harbor Beach

3. NAME OF DECEASED (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
Samuel	Athey	Ryan	Sept.	15	1949

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months.	Days	If under 24 hrs.: Hours	Min.
Male	White	Married	4-16-1897	52 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY
Real Estate	Realty	Virginia	U.S.A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Samuel E. Ryan	Bertie V. Pullam

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	If yes, give war or dates of service	16. SOCIAL SECURITY NO.	17. INFORMANT
Yes	WWI		Thelma L. Ryan

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
420.1 **Immediate cause**	(a) Coronary Thrombosis	1/2 Hour
Antecedent cause(s)		
94a Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b)	
	(c)	

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Thrombophlebitis LEFT Leg.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour)	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?
m.		

22. I hereby certify that I attended the deceased from July, 1949, to Sept 15 1949, that I last saw the deceased alive on Sept 13, 1949 and that death occurred at 1:10 A m., from the causes and on the date stated above.

SIGNATURE (Degree or title)	ADDRESS	DATE SIGNED
Edward Chenault M.D.	Gambrills Md	Sept 15, 1949

23. BURIAL, CREMATION, REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	9-19-49	Arlington National	Arlington Virginia

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
Sept. 19, 1949	[signature]	John M. Taylor & Son	Annapolis, Md.

RECEIVED
SEP 20 1910
BUREAU F. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

08511

Reg. Dist. No. 21

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH: COUNTY Aa — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN West Annapolis — LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS 310 Monterey Ave

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md — COUNTY Aa
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN W. Annapolis
STREET ADDRESS (If rural give location) 310 Monterey Ave.

3. NAME OF DECEASED (Type or Print): (First) Lawrence (Middle) Franklin (Last) Sears

4. DATE OF DEATH: (Month) 9 (Day) 2 (Year) 1949

5. SEX: M.

6. COLOR OR RACE: W

7. SINGLE, ~~MARRIED~~, WIDOWED, ~~DIVORCED~~, (Specify)

8. DATE OF BIRTH: July 2-1918

9. AGE last birthday: 31 yrs. — If under 1 year: Months / Days — If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, eveu if retired)

10b. KIND OF BUSINESS OR INDUSTRY: Metal Works

11. BIRTHPLACE (State or foreign country): Baltimore Md.

12. CITIZEN OF WHAT COUNTRY: U.S.N.

13. FATHER'S NAME: Jerge W. Sears

14. MOTHER'S MAIDEN NAME: Grace E. Layman

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no — (If yes, give war or dates of service)

16. SOCIAL SECURITY No.

17. INFORMANT: Grace E. Sears

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

			INTERVAL BETWEEN ONSET AND DEATH
410	Immediate cause	(a) Coronary occlusion	1 hr.
92b	Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Mitral Insufficiency	10 yrs.
		(c)	

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While at Work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from July, 1949, to Sept 2, 1949, that I last saw the deceased alive on Sept 2, 1949, and that death occurred at 9:36 a.m., from the causes and on the date stated above.

SIGNATURE: James R. Martin (Degree or title) M.D. ADDRESS Annapolis Md. DATE SIGNED 9-3-49

23. BURIAL, CREMATION, REMOVAL (Specify) — DATE THEREOF Sept-5-49 — NAME OF CEMETERY OR CREMATORY Lorraine Cemetery — LOCATION (City, town, or county) Ballo (State) Md

DATE REC'D BY LOCAL REG. Sept. 5, 1949 — REGISTRAR'S SIGNATURE [illegible] — 24. FUNERAL DIRECTOR John M. Taylor Son — ADDRESS Annapolis Md

RECEIVED
SEP 7 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

118512

CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

Reg. Dist. No. 21

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15A

1. PLACE OF DEATH: COUNTY Anne Arundel; CITY OR TOWN Annapolis; LENGTH OF STAY (in this place) Dead on arrival; HOSPITAL OR INSTITUTION OR STREET ADDRESS Emergency Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland; COUNTY A. A.; CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) East Port; STREET ADDRESS (If rural, give location) 528 - 4th. Street

3. NAME OF DECEASED (Type or Print): (First) JOHN (Middle) WESLEY (Last) SIMMS

4. DATE OF DEATH: (Month) Sept. (Day) 11 (Year) 1949

5. SEX: Male

6. COLOR OR RACE: negro

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Single

8. DATE OF BIRTH: 1907

9. AGE last birthday: 42 yrs. If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Waiter + Cook

10b. KIND OF BUSINESS OR INDUSTRY: Restaurant

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY: U.S.A.

13. FATHER'S NAME: James L. Simms

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): (If yes, give war or dates of service): No

16. SOCIAL SECURITY No.:

17. INFORMANT: Pearl Selis.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		Interval Between Onset and Death
Immediate cause	(a) Coronary occlusion	Sudden
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Coronary sclerosis	unknown
	(c)	

420.1
94a

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☑

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY:

(CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at work ☐ Not while at work ☐

HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☑, Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

John M. Claffy, M.D. Deputy Medical Examiner Annapolis, Md 9-11-49

23. BURIAL, CREMATION, REMOVAL (Specify) DATE THEREOF NAME OF CEMETERY OR CREMATORY LOCATION (City, town, or county) (State)

Burial Sept 14 1949 Annapolis Memorial Gardens Eastport Md

DATE REC'D BY LOCAL REG. REGISTRAR'S SIGNATURE 24. FUNERAL DIRECTOR ADDRESS

Sept. 13, 1949 J. B. Johnson Annapolis

RECEIVED
SEP 14 1949
BUREAU T. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

08513

Reg. Dist. No. 28

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH: COUNTY: Anne Arundel; STATE: MARYLAND; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Millersville; LENGTH OF STAY (in this place): 15 Years; HOSPITAL OR INSTITUTION OR STREET ADDRESS: —

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE: Maryland; COUNTY: Anne Arundel; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Millersville; STREET ADDRESS (If rural, give location): —

3. NAME OF DECEASED (Type or Print): (First) Helen (Middle) Margaret (Last) Sisson

4. DATE OF DEATH: (Month) Sept (Day) 11 (Year) 1949

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married

8. DATE OF BIRTH: July 3 1871

9. AGE last birthday: 78 yrs. If under 1 year: Months. Days. If under 24 hrs.: Hours. Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: —

11. BIRTHPLACE (State or foreign country): Millersville Md

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Henry Woodward

14. MOTHER'S MAIDEN NAME: Margaret Elizabeth Anderson.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If year, give war or dates of service):

16. SOCIAL SECURITY NO.: None.

17. INFORMANT: Mrs Eleanor Coggins - Daughter

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		Interval Between Onset and Death
Immediate cause	(a) Uremia	10 days
572.3 Antecedent cause(s)	Chronic Nephritis	
131b Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Generalized Arterio-sclerosis	
	(c) Colitis - Cause Undetermined	10 Years

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify):

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY:

(CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Sept 1, 1949, to Sept 11, 1949, that I last saw the deceased alive on Sept 10, 1949, and that death occurred at 4:15 A m., from the causes and on the date stated above.

SIGNATURE: Edward J Merritt (Degree or title): M.D. ADDRESS: Cambrills DATE SIGNED: Sept 14 1949

23. BURIAL, ~~CREMATION~~ REMOVAL (Specify): DATE: 9/14 49 NAME OF CEMETERY OR CREMATORY: Seven Crossroads LOCATION (City, town, or county) (State): Millersville Md

DATE REC'D BY LOCAL REG. 9-11-49 REGISTRAR'S SIGNATURE: E T Joyce Local Reg.

24. FUNERAL DIRECTOR: D H Hines Co ADDRESS: 2901 14th Wash DC

RECEIVED
SEP 15 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

08514

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH — COUNTY: Anne Arundel — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Rural Point Pleasant
LENGTH OF STAY (In this place): 46 days.
HOSPITAL OR INSTITUTION OR STREET ADDRESS:

2. USUAL RESIDENCE (HOME) OF DECEASED — STATE: Baltimore — COUNTY:
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Baltimore Highlands
STREET ADDRESS (If rural, give location): 2911 Illinois Ave ✓

3. NAME OF DECEASED (Type or Print): (First) Joseph (Middle) Frank (Last) Smith
4. DATE OF DEATH: (Month) Sep. (Day) 22 (Year) 1949
5. SEX: male
6. COLOR OR RACE: white
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married
8. DATE OF BIRTH: May-20-1878
9. AGE last birthday: 71 yrs. If under 1 year: Months. Days. If under 24 hrs.: Hours. Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer retired
10b. KIND OF BUSINESS OR INDUSTRY: B&O Railroad
11. BIRTHPLACE (State or foreign country): Baltimore County
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: August Smith
14. MOTHER'S MAIDEN NAME: Rachel Hynes
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no (If year, give war or dates of service)
16. SOCIAL SECURITY NO.: none
17. INFORMANT: Mrs. Mary Smith (wife)

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

			Interval Between Onset and Death
420.1	Immediate cause	(a) Coronary Occlusion	3 hours
94a	Antecedent cause(s)	(b) coronary sclerosis	4 1/2 months
	Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(c) generalized arteriosclerosis	

II. OTHER SIGNIFICANT CONDITIONS — Conditions contributing to the death but not related to the disease or condition causing death: arterio-sclerosis of the brain

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from May-5, 1949, to Sep-6-, 1949, that I last saw the deceased alive on Sep-6-, 1949, and that death occurred at 4 30 a.m., from the causes and on the date stated above.

SIGNATURE: Walther H. Sonnenfeldt (Degree or title) M.D. ADDRESS: 2708 Hollins Ferry Rd. Balto 30. DATE SIGNED: 9/22/49

23. BURIAL, CREMATION REMOVAL (Specify): Burial
DATE: Sept 26 1949
NAME OF CEMETERY, OR CREMATORY: Meadowridge
LOCATION (City, town, or county) (State): Jessups-Md

DATE REC'D BY LOCAL REG.: 9/23/49
REGISTRAR'S SIGNATURE: A. W. Hedrick
24. FUNERAL DIRECTOR: Mr & Mrs. J. W. Teufel & Son ADDRESS: 5311 Edmondson Ave

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

08515

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH: COUNTY Anne Arundel MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS Emergency Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Anne Arundel
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN
STREET ADDRESS (If rural give location) R.F.D. #3

3. NAME OF DECEASED (Type or Print) (First) Rosella (Middle) (n) (Last) Smith
4. DATE OF DEATH (Month) 9 (Day) 19 (Year) 1949
5. SEX Female
6. COLOR OR RACE White
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)
8. DATE OF BIRTH 2-19-1880
9. AGE last birthday 69 yrs. If under 1 year Months Days If under 24 hrs. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife
10b. KIND OF BUSINESS OR INDUSTRY House
11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Unknown
14. MOTHER'S MAIDEN NAME Unknown
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. —
17. INFORMANT William A. Smith, Jr.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Cerebral Hemorrhage with left hemiplegia	1 week
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Hypertension	Several years
	(c) Arteriosclerosis	Several years

331
61

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Diabetes Mellitus — 10 years

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Sept, 1949, to Sept 19, 1949, that I last saw the deceased alive on Sept 19, 1949, and that death occurred at 1 30 p.m., from the causes and on the date stated above.

SIGNATURE George C Basil (Degree or title) M D ADDRESS Annapolis Md DATE SIGNED 9-20-49

23. BURIAL, CREMATION REMOVAL (Specify) Burial
DATE THEREOF 9-23-49
NAME OF CEMETERY OR CREMATORY Cedar Bluff
LOCATION (City, town, or county) Annapolis, (State) Md.
DATE REC'D BY LOCAL REG. Sept. 21, 1949
REGISTRAR'S SIGNATURE [signature]
24. FUNERAL DIRECTOR John M. Taylor Son ADDRESS Annapolis Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
SEP 23 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

08516

Reg. Dist. No. 2

1. PLACE OF DEATH: COUNTY A.A.CO.Md. MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Glenburnie
LENGTH OF STAY (in this place) 3 Wks.
HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Baltimore Md. COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN ~~Glen Burnie~~
STREET ADDRESS (If rural give location) 1337 N.Gay St.

3. NAME OF DECEASED (Type or Print): (First) Florence (Middle) M. (Last) Thomas

4. DATE OF DEATH: (Month) Sept. (Day) 8, (Year) 1949

5. SEX: female

6. COLOR OR RACE: white

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): widowed

8. DATE OF BIRTH: 2/12/1892

9. AGE last birthday: 57 yrs. If under 1 year: Months / Days. If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): at home

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country): North Carolina

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Not Known

14. MOTHER'S MAIDEN NAME: Not Known

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: Jack Thomas Glen Burnie Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

156.1 / 46 f

Immediate cause (a) Cancer of Liver — Interval between onset and death: 4 yr.

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Arteriosclerosis — 5 yr.

(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Ascites -

19a. DATE OF OPERATION: None.

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☑

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from July 20, 1949, to Sept. 8, 1949, that I last saw the deceased alive on Sept. 8, 1949, and that death occurred at 5 P. m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

Chas. L. Ball Jr. MD Linthicum Hgts. 9/8/49

23. BURIAL, CREMATION REMOVAL (Specify): Burial

DATE THEREOF: 9/10/49

NAME OF CEMETERY OR CREMATORY: Mt.Olivet

LOCATION (City, town, or county) (State): Frederick Ave.

DATE REC'D BY LOCAL REG. 9-9-49

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR ADDRESS: Clarence F.Hoffmann 1639 Broadway.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

08517

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Annapolis,
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Few hours

Hospital, institution, or street address where death occurred:
Vacant Lot, behind 420 Clay St.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Anne Arundel

City or town: Annapolis
(If outside city or town limits, write RURAL and give nearest town)

Street No.: Unknown
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME
Unknown colored baby girl

3.(b) Social Security Number
None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Colored	Single

6.(b) Name of husband or wife: None

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): September 25 1949

8. AGE: Years | Months | Days | If less than one day: 5 hrs. ? min.

9. Birthplace: Unknown
(Town, county, and state)

10. Usual occupation: None

11. Industry or business

FATHER
12. Name: Unknown
13. Birthplace

MOTHER
14. Maiden name: Unknown
15. Birthplace

16. Informant: Police of Annapolis, Maryland.

Address

17. Burial
(Burial, cremation, or removal. Which?)

Date thereof: Sept. 27, 1949
(month) (day) (year)

Cemetery or crematory: Patters Field

Location: Near Spa Road

18. Funeral director: Mrs Charles E. Hicks + Son

Address: 43-45 northwest st Annapolis md.

19. Sept. 27 1949
(Date rec'd by registrar)

[signature] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: September 25th 1949, at 7.A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..., to ..... 19.....

and that I last saw h..... alive on ..... 19.....

Immediate cause of death: Exposure — DURATION: 5hrs

Due to

Due to

Other conditions

983
195C
(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Homicide Date of 9/25/49

Where did injury occur? (City or town) Annapolis (County) (State)

Injured at home, farm, industry, public place (where?) Vacant Lot

Means of injury Injured at work?

23. SIGNATURE: Gustave H. Paulsen M.D.
Instant Deputy Med Exam M. D., or other

Address: Glen Burnie, Md. Date signed 9/26/49

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
SEP 28 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

08518

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH: COUNTY Anne Arundel MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Crownsville
LENGTH OF STAY (in this place) 24 years
HOSPITAL OR INSTITUTION OR STREET ADDRESS (Crownsville State Hosp.)

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md. COUNTY A. A.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Crownsville
STREET ADDRESS (If rural, give location) Crownsville Hospital

3. NAME OF DECEASED (Type or Print) (First) A. (Middle) Earl (Last) Walters

4. DATE OF DEATH (Month) Sept. (Day) 14 (Year) 1949

5. SEX Male

6. COLOR OR RACE White

7. SINGLE, ~~MARRIED~~, ~~WIDOWED~~, ~~DIVORCED~~, (Specify) Single.

8. DATE OF BIRTH about June 26, 1891

9. AGE last birthday 58 about yrs. If under 1 year Months Days If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Hospital Attendant.

10b. KIND OF BUSINESS OR INDUSTRY State Hosp.

11. BIRTHPLACE (State or foreign country) Pa.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Adolphus Gills Walters

14. MOTHER'S MAIDEN NAME Elizabeth Harclerode

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. no

17. INFORMANT Mr. Harry E. Walters 202 Valley St. Marysville, Pa.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
592 Immediate cause	(a) Mitral Insufficiency	1 1/2 years
131a Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Interstitial chronic nephritis	1 1/2 y.
	(c)	

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION —

19b. MAJOR FINDINGS OF OPERATION —

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify) —
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) —
(CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR? —

22. I hereby certify that I attended the deceased from February, 1947, to 9/14, 1949, that I last saw the deceased alive on 9/12, 1949, and that death occurred at 8.30 p. m., from the causes and on the date stated above.

SIGNATURE Gustave H. Faucher (Degree or title) M.D. ADDRESS Glen Burnie Md. DATE SIGNED 9/14/49

23. BURIAL, CREMATION REMOVAL (Specify) Removal
DATE THEREOF 9/17/49
NAME OF CEMETERY OR CREMATORY Trinity Ev. Re. Ch. Cem.
LOCATION (City, town, or county) (State) Friends Cove, Bedford Pa.

DATE REC'D BY LOCAL REG. 9-16-49
REGISTRAR'S SIGNATURE A. W. Hedrick
24. FUNERAL DIRECTOR WM. J. TICKNER & SONS ADDRESS Balto., Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

Evidence for change of age shown on:

MARYLAND STATE DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

08519

Reg. Dist. No. 22

FILM No. G 122 OCT 17 1949

1. PLACE OF DEATH: COUNTY Anne Arundel. MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Laurel - Rural
LENGTH OF STAY (in this place) 12 years
HOSPITAL OR INSTITUTION OR STREET ADDRESS District Training School

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE District of Columbia COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Washington
STREET ADDRESS (If rural, give location) 314 - 58th St. N.E.

3. NAME OF DECEASED (Type or Print) (First) Jefferson (Middle) (Last) Warren
4. DATE OF DEATH (Month) Sept. (Day) 17 (Year) 1949
5. SEX Male
6. COLOR OR RACE Colored.
7. SINGLE, ~~MARRIED~~, ~~WIDOWED~~, ~~DIVORCED~~, (Specify) single.
8. DATE OF BIRTH 2/3 ~~[illegible]~~ 31
9. AGE last birthday 18 yrs. If under 1 year Months Days If under 24 hrs. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None.
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Washington - D.C.
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Clarence Warren
14. MOTHER'S MAIDEN NAME ??
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. None.
17. INFORMANT District Training School - Records.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		Interval Between Onset and Death
Immediate cause	(a) Pneumonia	10 hrs.
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Accidental poisoning due to overdose of turpentine. -	41 hrs.
	(c) Nephritis	10 hrs.

882.0
179 x

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Mongolian Ament. (Idiot) Life

19a. DATE OF OPERATION —
19b. MAJOR FINDINGS OF OPERATION None
20. AUTOPSY? Yes ☐ No ☐

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☑ CAUSE OF DEATH.
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) District Training School - (CITY OR TOWN) Laurel. (COUNTY) A.A. (STATE) Md.
TIME OF INJURY (Month) (Day) (Year) (Hour) 9/15/49 1.45 p.m.
INJURY OCCURRED While at work ☐ Not while at work ☑
HOW DID INJURY OCCUR? Drank overdose of Turpentine (12 oz.)

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☐, Inquiry ☑ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE Gustave H. Faucher M.D. (Degree or title) Assistant Deputy M.E. ADDRESS Glen Burnie, Md. DATE SIGNED 9/17/49

23. BURIAL, CREMATION REMOVAL (Specify) DATE THEREOF 9-17-49 NAME OF CEMETERY OR CREMATORY ? LOCATION (City, town, or county) Washington (State) D.C.

DATE REC'D BY LOCAL REG. 9-17-49 REGISTRAR'S SIGNATURE Clara Haslup
24. FUNERAL DIRECTOR H. S. Washington & Sons ADDRESS 467 N. St. N.W. Wash. D.C.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A

RECEIVED
OCT 12 1949
BUREAU V. S.

08520

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 21

M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

I

VS. A15

T

1. PLACE OF DEATH · COUNTY: A. A. Co — MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED · STATE: Maryland — COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Annapolis — LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Arnold
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Emergency Hospital	STREET ADDRESS (If rural give location): Shore Acres

3. NAME OF DECEASED (Type or Print) (First) Theresa (Middle) M. (Last) Wendt	4. DATE OF DEATH (Month) Sept (Day) 26 (Year) 1949
5. SEX: Female — 6. COLOR OR RACE: White — 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widow — 8. DATE OF BIRTH: Jan 23 1878	9. AGE last birthday: 71 yrs. — If under 1 year: Months / Days — If under 24 hrs.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House Wife — 10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country): Germany — 12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: Wilhelm Yung	14. MOTHER'S MAIDEN NAME: Unknown
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) — 16. SOCIAL SECURITY No.	17. INFORMANT: George W. Wendt 2000 Wilhelm St Balto Md

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

331 Immediate cause (a) Cerebral hemorrhage — 3 wks.

83a Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Mental shock brought on by sudden death of husband (?) — 4½ wks.

(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	(CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Sept 6, 1949, to Sept 26, 1949, that I last saw the deceased alive on Sept 25, 1949, and that death occurred at 10:15 A m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
Maurice Klawans		Annapolis Md	9/26/49

23. BURIAL, CREMATION REMOVAL (Specify): Burial	DATE THEREOF: 9/29/49	NAME OF CEMETERY OR CREMATORY: Cedar Hill	LOCATION (City, town, or county) (State): A A Co Md
DATE REC'D BY LOCAL REG.: 9/27/49	REGISTRAR'S SIGNATURE: A.W. Hedrick Dm	24. FUNERAL DIRECTOR: Kott C and B. M. Walters	ADDRESS: Pratt & Stricker sts Balto Md

08521

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 21

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: COUNTY Anne Arundel. MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis
LENGTH OF STAY (in this place) 1 yr.
HOSPITAL OR INSTITUTION OR STREET ADDRESS Emergency

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY A.A.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis
STREET ADDRESS (If rural give location) 33 Taylor St.

3. NAME OF DECEASED (Type or Print): (First) Bonita (Middle) Audrey (Last) Wilson
4. DATE OF DEATH: (Month) Sept. (Day) 2 (Year) 1949

5. SEX: Female
6. COLOR OR RACE: Col
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)
8. DATE OF BIRTH: Aug. 18, 1948
9. AGE last birthday: 1 yrs. If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country): Annapolis, Md.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: James Wilson
14. MOTHER'S MAIDEN NAME: Roseme Williams

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: James Wilson

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

			Interval Between Onset and Death
341	Immediate cause	(a) Cerebral Hemorrhage	about 24 hrs
83a	Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Sinus Thrombosis	? 2 days.
		(c)	

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Diarrhea

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☒ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 8-31, 1949, to 9-2, 1949, that I last saw the deceased alive on 9-1, 1949, and that death occurred at 4:55 A. m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED
E. Peabody Trenton M.D. 240 Prince George - Annapolis 9.3.49

23. BURIAL, CREMATION REMOVAL (Specify): Burial
DATE THEREOF: Sept. 5-49
NAME OF CEMETERY OR CREMATORY: St. Mary's
LOCATION (City, town, or county) (State): Annapolis Md.

DATE REC'D BY LOCAL REG.: Sept. 4, 1949
REGISTRAR'S SIGNATURE: [signature]
24. FUNERAL DIRECTOR ADDRESS: Mrs. Charles E. Yates & Son

VS. A15

RECEIVED
SEP 7 1949
BUREAU V. S.

08522

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 20

M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

I

VS. A15

1. PLACE OF DEATH: COUNTY: Anne Arundel Co MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED: STATE: ~~Salisbury~~ Maryland COUNTY: A.A. Co
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Salisville — LENGTH OF STAY (in this place): Lifetime	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Salisville A.A. Co.
HOSPITAL OR INSTITUTION OR STREET ADDRESS: —	STREET ADDRESS (If rural, give location): Salisville — A.A. Co.

3. NAME OF DECEASED (Type or Print)	(First) Bessie	(Middle) May	(Last) Woodfield	4. DATE OF DEATH	(Month) Sep. (Day) 24 (Year) 1949
5. SEX: Fmeal	6. COLOR OR RACE: White	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married	8. DATE OF BIRTH: 5/26/1882	9. AGE last birthday: 67 yrs.	If under 1 year: Months. 2 Days; If under 24 hrs.: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife	10b. KIND OF BUSINESS OR INDUSTRY: Home	11. BIRTHPLACE (State or foreign country): Annapolis Md	12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME: John Wesley Sears	14. MOTHER'S MAIDEN NAME: Mary Elizabeth Phipps				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)	16. SOCIAL SECURITY No.	17. INFORMANT AND ADDRESS: William Woodfield			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Cancer of the liver	1 yr.
157 Antecedent cause(s)		
46g Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Cancer of the Pancreas	1 yr.
	(c)	

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: 7/26/49	19b. MAJOR FINDINGS OF OPERATION: Cancer of the Pancreas with metastases to the liver	20. AUTOPSY? Yes ☐ No ☐
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)	
TIME OF INJURY (Month) (Day) (Year) (Hour) m.	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 1/1/49, 19.., to 9/24/49, 19....., that I last saw the deceased alive on 9/24/49, 19....., and that death occurred at 2:20 p.m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
Albert L. Anderson	MD	Annapolis, Md	9/24/49

23. BURIAL, CREMATION REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	Sept 27, 1949	Woodfields	Galesville Md

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
Sept 27/49	W. W. Clayton Dep Regist.	T. A. Hardesty & Son	

RECEIVED
OCT 3 1949
BUREAU V. S.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 25

BIRTH NO.

1. NAME OF DECEASED (Type or Print): MARY E YOUNGER

2. DATE OF DEATH: 9-17-49

3. PLACE OF DEATH:
A. ~~Baltimore City~~, Maryland — Brooklyn
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Anne Arundel 327 ORCHARD Ave
C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MARYLAND
B. COUNTY: Anne Arundel
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): ~~BALTIMORE~~
D. STREET ADDRESS (If rural, give location): 327 ORCHARD AVE BROOKLYN.

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
FEMALE	WHITE	WIDOWED	3-1-75	74		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
HOUSEWIFE	—	PENNA	—

13. FATHER'S NAME: EDWARD ~~[illegible]~~ MANNION

14. MOTHER'S MAIDEN NAME: ANNA CLARK

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.
—	—	—

17. INFORMANT: Miss MARY YOUNGER — ADDRESS: 327 ORCHARD

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Uremia — INTERVAL BETWEEN ONSET AND DEATH: 9/10/49

DUE TO

(B) Hypertensive Cardio - Vascular

DUE TO

(C) Renal Disease

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

442
B1a

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Oct. 10, 1947 *to* Sept 17, 1949, *that I last saw the deceased alive on* Sept 17, 1949, *and that death occurred at* 7A. m., *from the causes and on the date stated above.*

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Chas Lellin M.D. M. D.	320 Patapsco Ave	9/18/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
BURIAL	9-21-49	CEDAR Hill Cem	ANNAPOLIS Blvd - BALTO. MD

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
9/19/49	H W Hedrick Sr	THOMAS J. KENNY, INC.	1600 Hollins St

VS 150

VS. A15

MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.